5-000 The Mental Health and Substance Abuse (MH/SA) Package

5-001 Introduction: 482 NAC 5-000 sets forth the responsibilities of the MH/SA provider and MH/SA plan in delivering the MH/SA Package to the Nebraska Health Connection (NHC) client. While the provider is responsible for providing services to the client, the MH/SA plan, as the contracting entity with the Department, assumes primary administrative and operational responsibility for the development and implementation of the NHC programmatic requirements. In developing its program for the delivery of the MH/SA Package, and all related aspects of the NHC the MH/SA plan shall incorporate the information contained in this Title, as well as 471 NAC, which defines in detail the minimum service provisions required for the NHC under the Nebraska Medical Assistance Program.

5-001.01 Mandatory Clients for the Mental Health/Substance Abuse Package: The following Medicaid-eligible clients are required to participate in the NHC on a statewide basis, unless excluded in 482 NAC 5-001.02:

1. Clients participating in the Aid to Dependent Children Program - Grant/Medical (see Title 468 NAC). For purposes of the NHC, this includes clients participating in the Medical Assistance Programs for Children (i.e., Ribicoff), Medical Assistance for Children (MAC), School Age Medical (SAM) and Kids Connection (see Title 477 NAC);
2. Clients participating in the Aid to Aged, Blind, and Disabled Program - Grant/Medical (see Title 469 NAC); and
3. Clients participating in the Child Welfare Payments and Medical Services Program (i.e., IV-E, Non-IV-E, Former Wards, Subsidized Guardianship cases) (see Title 479).

The client's managed care status (mandatory or excluded) is determined by an automated interface between the Department's eligibility system and the Managed Care File, and is based on information entered on the eligibility system by the Health and Human Services' local office staff, and known at the time of the managed care determination (see 482-000-2, NHC Determination Logic).

5-001.02 Excluded Clients: The following clients are excluded from the NHC:

1. Clients residing in nursing facilities and receiving custodial care (see 471 NAC 12-000 and 482 NAC 2-004.04);
2. Clients residing in intermediate care facilities for the mentally retarded (ICF/MR) (see 471 NAC 31-000);
3. Clients who are residing out-of-state (i.e., children who are placed with relatives out-of-state, and who are designated as such by HHS personnel);
4. Certain children with disabilities who are receiving in-home services (also known as the Katie Beckett program) (see 469 NAC 2-010.01F);

5. Aliens who are eligible for Medicaid for an emergency condition only (see Titles 468, 469, 477, 479 NAC);
6. Clients participating in the Refugee Resettlement Program - Grant/Medical (see Title 470 NAC);
7. Clients receiving services through the following home and community-based waivers (see Title 480 NAC) for -
   a. Adults with mental retardation or related conditions;
   b. Aged persons or adults or children with disabilities;
   c. Children with mental retardation and their families;
   d. Infants and toddlers with disabilities (also known as the Early Intervention Waiver); and
   e. Any other group for whom the Department has received approval of a 1915(c) waiver of the Social Security Act;
8. Clients who have excess income (i.e., spenddown - met or unmet) (see 471 NAC 3-000);
9. Clients participating in the State Disability Program (see Title 469 NAC);
10. Clients eligible during the period of presumptive eligibility (see 471 NAC 28-000);
11. Transplantation recipients (see 471 NAC 10-000 and 482 NAC 2-004); and
12. Clients who have received a disenrollment/waiver of enrollment (see 482 NAC 2-004).

The client shall have the opportunity to choose his/her MH/SA provider from the providers participating in the MH/SA plan network; however, the client does not have a choice of MH/SA plan as there is only one plan providing the MH/SA package on a statewide basis.

Medicaid coverage for clients excluded from NHC participation remains on a fee-for-service basis. Clients who are excluded from NHC cannot voluntarily enroll in the NHC.

Due to changes in a client's Medicaid eligibility and managed care status, a client's status may periodically change. The MH/SA plan is responsible for the provision of the NHC MH/SA Package for the client as long as s/he is identified as a member of the MH/SA plan.

5-001.03 Enrollment for the Mental Health and Substance Abuse MH/SA Package: Clients are enrolled for the MH/SA Package by virtue of their eligibility for Medicaid in the categories listed in 482 NAC 5-001.01. There is no separate enrollment process for these services. The MH/SA plan shall agree to accept Medicaid clients in the order in which they are enrolled.

5-001.03A Changes in Eligibility: Changes in the client's eligibility may affect his/her NHC status, e.g., mandatory or excluded. The client receives a notice each time s/he moves in and out of the NHC.

5-001.03B Effective Date of MH/SA Coverage: In the designated coverage area for the Basic Benefits Package, the client's enrollment into the MH/SA Package may begin prior to his/her enrollment for the Basic Benefits Package.

The MH/SA plan is responsible for the client effective with the date of MH/SA coverage under the NHC regardless of the client's level of care at the time of enrollment.

The first payment to the plan begins the first month of NHC coverage. The effective date of NHC coverage is the first day of the month following the month during which eligibility for the Nebraska Medical Assistance Program and mandatory status for the NHC is determined, given system cutoff.

5-001.03C MH/SA Services Before Enrollment in NHC: If eligibility for the Nebraska Medical Assistance Program (NMAP) is determined, Medicaid-coverable MH/SA services received before the month of NHC coverage in the MH/SA Package will be paid on a fee-for-service basis under the rules and regulations of the NMAP in 471 NAC.

5-001.03D Notification of NHC Coverage: The client or the client's legal representative will be notified of NHC coverage and will be issued a notice of finding and the NHC ID Document (see 482-000-9, Sample of NHC Client Notices and ID Document).

The MH/SA plan will be notified of enrolled clients via a monthly enrollment report (in the form of a data file). The Department electronically transmits the enrollment report to the MH/SA plan on or before the first day of each enrollment month. The enrollment report provides the plan with ongoing information about its clients and will be used as the basis for the monthly capitation payments (see 482-000-10, Enrollment Report File Layout).

The MH/SA plan is responsible for providing the NHC MH/SA Package to clients listed on the enrollment report generated for the month of enrollment. Any discrepancies between the client notification and the enrollment report will be reported to the Department for resolution. The MH/SA plan shall continue to provide and authorize services until the discrepancy is resolved. The Department will be responsible for all covered services in the event that a client is eligible for NHC MH/SA Package but it is not reflected on the enrollment report.

The Department's Eligibility and Enrollment databases used to build the Enrollment File is the official source of validation in the case of a discrepancy. Once the cause for the discrepancy is identified, the Department shall work cooperatively with the MH/SA plan to identify responsibility for the client's services until the cause for the discrepancy is corrected. In reconciling the discrepancy, an adjustment will be made in the following manner:

1. If the Department assumes claims payment for the client, the MH/SA plan shall reimburse the Department for any capitation payment made for that month of service;
2. If the MH/SA plan assumes claims payment for the client, the MH/SA plan shall receive a capitation payment; and
3. If the error results in an incorrect amount of capitation payment, the difference will be appropriately reimbursed, either to the MH/SA plan or to the Department.

The rules for reconciliation and reimbursement shall apply unless specifically addressed elsewhere.

5-001.03E Transition Period: Within the first month of enrollment, the MH/SA plan is responsible for providing each member general information about the MH/SA plan, e.g., member handbook, etc.

The MH/SA plan shall work cooperatively with a client who is experiencing difficulty in transitioning to a managed care environment during the first sixty days of enrollment.

The MH/SA plan shall continue all services that have been authorized by the Department or the Department's Peer Review Organization (PRO) prior to the client becoming enrolled in the NHC. These services shall be continued until the MH/SA plan determines that the service no longer meets the definition of medical necessity.

For a client who is specifically identified to have a special need, the MH/SA plan is responsible for coordinating service needs with the EBS, the MH/SA provider and the client during the first sixty days of enrollment to ensure a smooth transition into managed health care.

The transitional period may require, but is not limited to, the MH/SA plan providing additional case management and member services, contracting with out-of-network providers to ensure continuity of care, and taking into consideration the unique needs of the client in understanding and following the managed care rules, e.g., referral and prior authorization for services.

5-001.04 Disenrollment/Waiver of Enrollment: See 482-000-14, Disenrollment/Waiver of Enrollment Procedure Guide.

5-001.04A Disenrollment Due to Eligibility Changes: Disenrollment shall occur automatically in the following situations:

1. The client's Medicaid case is closed or suspended;
2. A sanction is imposed on the client; or
3. The client is no longer mandatory for NHC.

The Department shall notify the client and MH/SA plan of the disenrollment/waiver of enrollment. Disenrollment is prospective and is effective the first month possible, given system cutoff.

5-001.04B Disenrollment/Waiver of Enrollment Due to Special Circumstance: The Department shall manually disenroll/waive the client in the following situations by entering the disenrollment/waiver of enrollment in the Managed Care File (see 482-000-5):

1. The client is a transplant recipient (see 482-000-15); or
2. The client is residing out of the designated coverage areas and the Department determines it is no longer appropriate for the client to remain in the MH/SA and/or the Basic Benefits Package of the NHC.

The disenrollment is prospective and is effective the first month possible following the decision, given system cutoff. A waiver of enrollment occurs prior to any enrollment activities being completed.

Only the client may request a disenrollment, or waiver of enrollment. The disenrollment or waiver of enrollment, if approved, applies until the reason for the disenrollment or waiver of enrollment no longer applies.

The Department shall enter the status of the request in the Managed Care File. Note: The client may be disenrolled from the Basic Benefits Package and/or Mental Health/Substance Abuse (MH/SA) components of the NHC.

The Department shall notify the client of the disenrollment/waiver of enrollment, whether s/he is waived from the Basic Benefits Package and/or the MH/SA components, and whether s/he shall remain eligible for Medicaid on a fee-for-service basis.

The Department shall report all disenrollments to the MH/SA plan on the enrollment report.

5-001.04B1 Disenrollment/Waiver of Enrollment for Pregnant Woman: The Department shall manually disenrollment/waive enrollment by entering the disenrollment/waiver of enrollment on the Managed Care File (see 482-000-5) for a client whose mandatory status for NHC begins in her third trimester of pregnancy and who is seeking care from a provider (i.e., primary care physician or hospital) not affiliated with a MH/SA plan, or is affiliated with the MH/SA plan but is closed to new enrollment.

A waiver of enrollment occurs prior to any enrollment activities being completed.

Disenrollment (i.e., due to an enrollment where pregnancy is not known, such as auto-assignment) or waiver of enrollment requests can only be made by the client and/or the EBS.

The disenrollment/waiver of enrollment is effective until the reason for the waiver of enrollment no longer applies. In the case of a pregnant woman, this provision would apply through the postpartum period, defined as the end of the month in which the 60th day following the end of the pregnancy occurs.

If the request is submitted to the EBS, the EBS shall submit the request, including required forms and documentation, to the Department within two working days of the request. The Department shall enter the waiver of enrollment the first month possible, given system cutoff.

The Department shall enter the status of the request in the Managed Care File. Note: The client may be disenrolled from the Basic Benefits Package and/or Mental Health/Substance Abuse (MH/SA) components of the NHC.

The Department shall notify the client of the disenrollment/waiver of enrollment, whether s/he is waived from the Basic Benefits Package and/or the MH/SA components, and whether s/he shall remain eligible for Medicaid on a fee-for-service basis.

The Department shall report all disenrollments to the MH/SA plan on the enrollment report (see 482-000-10).

5-001.04C General Requirements: The client shall contact the EBS to request a disenrollment/waiver of enrollment. If the client is currently enrolled in managed care at the time of the request, the EBS will work with the client to attempt to resolve the reason(s) for the client's request, if applicable. At a minimum, the EBS shall:

1. Explore the reason(s) for the client's request;
2. Review the client's status at the time of enrollment to ensure the current enrollment adequately addresses the client's situation, e.g., nurses notes, health assessment, type of enrollment, etc.;
3. Provide the client with information/education regarding managed care;
4. Explain the regulatory provisions to participate in managed care, and the limited provision for granting disenrollments; and
5. Explore viable alternatives within NHC.

If the client is not yet enrolled in managed care at the time of the request, the EBS will work the client to complete the enrollment activities, including completion of the health assessment if in the designated coverage area for the Basic Benefits Package.

If it is not possible to resolve the client's concerns, the EBS will proceed with processing a formal client request for disenrollment/waiver of enrollment that includes the following information:

1. Documentation of the activities completed with the client in steps 1-5 above, and with the provider and MH/SA plan, to resolve the client's concern(s), including the reason the client has requested a disenrollment;
2. The written request from the client, if the request was submitted in writing;
3. Information from the provider and MH/SA plan regarding his/her recommendation for or against the disenrollment/waiver of enrollment with supporting information/documentation for this recommendation; and
4. An independent EBS assessment of the client's current medical/social situation, including the reason the client wants the disenrollment/waiver of enrollment, the attempts at resolving the situation, the results of these attempts, all viable alternatives both within and outside managed care with expected outcomes of each.

The EBS shall forward all of the above documentation to the Department (ATTN: Managed Care Unit) on Form NHC-7, Request for Disenrollment/Waiver of Enrollment Form, within two working days of the request/completed documentation. The Department shall approve or deny the disenrollment/waiver of enrollment within five working days.

The EBS shall make reasonable efforts to obtain documentation from the provider(s) providing care to the client prior to submitting the request to the Department but shall not delay submission of the request for more than ten working days.

For a client who is already enrolled, the effective date of disenrollment/waiver of enrollment is the first day of the month following the decision and no later than the second month. The Department will manually remove the client from "mandatory" managed care status.

A client may be disenrolled or waived out of one or both NHC components: the Basic Benefits Package and/or the Mental Health/Substance Abuse Package.

Some disenrollments/waivers of enrollment are permanent, e.g., transplantation; while others will be approved for a specified period of time, e.g., pregnancy-related. These time limits will be identified on the client's Notice of Finding, and will be reported to the EBS. As appropriate, the Department will monitor the duration of the approval.

The Department shall coordinate any Department-initiated request for disenrollment/waiver of enrollment with the EBS. The EBS will work with the client in exploring resolution to the issue, prior to processing the request.

A Notice of Finding will be issued to the client indicating whether the request for disenrollment/waiver of enrollment was approved. For a client who is already enrolled in managed care, the client's provider and MH/SA plan will receive notification of the disenrollment on the monthly Enrollment Report (see 482-000-9).

For a client who is not enrolled, notification to the MH/SA plan is not required.

In some cases, the decision to deny/approve the request for disenrollment/waiver of enrollment will be delayed, for up to two weeks, pending receipt of additional information. If no further documentation is received, the request for disenrollment/waiver of enrollment will be denied for lack of sufficient documentation.

The disenrollment/waiver of enrollment applies until the reason for the disenrollment/waiver of enrollment is no longer applicable. The duration of the disenrollment/waiver of enrollment will be monitored on a periodic basis by the Department.

Nothing precludes the client from requesting subsequent request should his/her situation change substantially. The client may also file an appeal of the decision pursuant to 465 NAC (see 482 NAC 7-000).

5-002 MH/SA Provider: The following provisions describe the MH/SA provider's responsibilities in the NHC.

5-002.01 Types of Providers: In the MH/SA plan, MH/SA services may be provided by psychiatrists/physicians, licensed psychologists, nurses, licensed mental health practitioners, appropriate trained para-professionals, and certified alcohol and drug abuse counselors, or doctoral/masters level professionals in the process of licensure. Services must be within the scope of practice for that provider type. Other appropriately licensed/certified providers may provide services listed in 482 NAC 5-006 as defined in 471 NAC 20-000 and 32-000 within the scope of practice and licensure.

5-002.02 Limit on Number of Clients: There are not any limitations on the number of clients that a MH/SA provider is allowed to provide MH/SA services to in the NHC, as long as the quality of service is not jeopardized by the number of clients.

5-002.03 MH/SA Provider Qualifications and Responsibilities: To participate in the NHC, the MH/SA provider must:

1. Be a Medicaid-enrolled provider and agree to comply with all pertinent Medicaid regulations. The MH/SA plan may reimburse a non-Medicaid enrolled provider if the service being provided is a non-Medicaid coverable service;
2. Sign a contract with the MH/SA plan as a provider which explains the provider's responsibilities and compliance with the following NHC requirements:
    a. Treat NHC clients in the same manner as other patients;
    b. Provide services within the MH/SA Package per 471 NAC to all clients according to the Enrollment Report (see 482-000-9) and comply with all requirements for referral management and prior-authorization in the most appropriate and least restrictive level of care;
    c. Coordinate appropriate referrals to MH/SA or primary care services;
    d. As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs clients such as accommodations for the deaf and hearing impaired, persons with dual-diagnosis, etc.;
    e. Ensure or provider continuous access to MH/SA services and necessary referrals of urgent or emergent nature available 24-hour, 7 days per week, access by telephone to a live voice (an employee of the MH/SA or an answering service) or an answering machine that shall immediately page an on-call MH/SA professional so referrals can be made for non-emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours;
    f. Not refuse an enrollment or disenroll a client or otherwise discriminate against a client solely on the basis of age, sex, race, physical or mental handicap, national origin, type of illness or condition, except when that illness or condition can be better treated by another provider type;

g. Ensure compliance with ADA requirements, utilizing appropriate technologies, other resources to accommodate a client's special needs, e.g., TTY/TDD and signing services;
h. Continue to be responsible for the client as a patient until another provider is located;
i. Comply with 482 NAC 5-004.07 if disenrolling from participation in the NHC and notify the MH/SA plan in a timely manner so that another provider can be located;
j. Maintain a medical record for each client and comply with the requirement to coordinate the transfer of medical record information if the client selects another provider;
k. Utilize the Enrollment Broker Services and Public Health Nursing components of the NHC (see 482 NAC 2-000 and 3-000) as appropriate;
l. Maintain a communication network providing necessary information to the client's primary care physician as frequently as necessary based on the client's needs.

Note: Many MH/SA services require concurrent and related medical services, and vice versa. These services, include, but are not limited to anesthesiology, laboratory services, EKGs, EEGs, and scans. The responsibility for coordinating services between the Basic Benefits Package (see 482 NAC 4-000) and the MH/SA Package (see 482 NAC 5-000), and in sharing and coordinating case management activities, is shared by providers in both areas.

A focused effort to coordinate the provision, authorization, payment and continuity of care is a priority for providers participating in the NHC. Each plan shall monitor overall coordination between these two service areas, i.e., medical/surgical and MH/SA. The plan shall ensure the PCP is knowledgeable about the MH/SA Package and other similar services and ensure that appropriate referrals are made to meet the needs of the client;
m. Communicate with agencies including, but not limited to, local public health agencies, community-based MH/SA agencies, etc.;
n. Provide information to the Department as required, including the Child Welfare worker and others involved with the care coordination of services for a child who is a ward in an out-of-home placement;
o. Inform clients about all treatment options, regardless of cost or whether such services are covered by the Nebraska Medical Assistance Program; and

3. Provide accurate information to the plan in a timely manner as requested so that information can be exchanged with the Department.

5-002.04 MH/SA Provider Non-Participation: A MH/SA provider may decide to not participate in the NHC. If the MH/SA provider is disenrolled from NHC, s/he may remain active as a Medicaid provider on a fee-for-service basis for clients not participating in the NHC if all Department regulations continue to be met. It is the MH/SA plan's responsibility to ensure adequate coverage for enrolled clients.

5-002.05 Managed Care Plan: The NHC delivers the MH/SA Package to Medicaid clients through a prepaid health plan (PHP). The following provisions describe the MH/SA plan's responsibilities in the NHC.

5-002.05A General Requirements: The NHC delivers the MH/SA Package to Medicaid clients through a prepaid health plan (PHP). The MH/SA plan is responsible for establishing a statewide system of MH/SA services. The MH/SA plan is required to comply with, but is not limited to, the following general requirements:

1. Provide the MH/SA Package according to all provisions in this RFP and 471 NAC and ensure the MH/SA Package is provided to clients in the same manner (i.e., in terms of timeliness, amount, duration, quality and scope) as those services provided to the non-managed care Medicaid client;
2. Provide for appropriate out-of-state services that meet the requirements of 471 NAC;
3. Use only providers enrolled in Nebraska Medical Assistance Program (NMAP) to provide the MH/SA Package under the NHC, ensure that the MH/SA providers participating in the MH/SA plan's network comply with all provider requirements identified in this RFP and in 471 NAC, and that all MH/SA services provided comply with appropriate staffing standards;
4. Provide a full array of services along a continuum of care in accordance with 471 NAC 20-000, 32-000, including active treatment;
5. Develop services, where services are lacking;
6. Provide services that are solution-focused, with time limited treatment and intervention, and that follow appropriate protocols for, but not limited to, treatment planning, transitional and discharge planning, clinical record-keeping, inspections of care, pre-treatment assessments, utilization review, after-care, care management, service coordination, travel to the home of handicapped individuals, provider payment, and appeals procedures according to 471 NAC;
7. Provide access to MH/SA services and necessary referrals 24 hours per day, 7 days per week;
8. Provide a communication network that provides necessary information to each MH/SA provider, as frequently as necessary based on the client's needs;
9. Provide a full continuum of MH/SA providers as defined in Section 4-002 and maintain sufficient numbers of qualified and experienced MH/SA providers to ensure adequate access to clients enrolled in the NHC;
10. Notify the client of a change in MH/SA providers;
11. Credential MH/SA providers for the provision of MH/SA Package services in a timely fashion;

12. Provide an appropriate range of services and access to MH/SA services on a statewide basis, and maintain a sufficient number, mix, and geographic distribution of providers that are skilled in areas such as cultural diversity and sensitivity, languages, accessibility to clients with mental, physical and communication disabilities, etc.;
13. Provide services directly or arrange for services through subcontractors;
14. Accept the client's choice of providers;
15. Provide case management (see 482-000-23);
16. Provide a client handbook, a comprehensive list of providers, and other informational materials about the MH/SA Package to the clients enrolled with the MH/SA plan. Maintain written policies and procedures and provide such information to clients in a manner appropriate to the client's needs. The plan is prohibited from performing any direct solicitation to individual Medicaid clients. Any general marketing to Medicaid clients must be approved by the Department prior to implementation.

    The MH/SA plan shall comply with the following marketing guidelines (see 482-000-24):

    a. Obtain Department approval for all marketing materials;
    b. Ensure marketing materials do not contain any false or potentially misleading information (in a manner that does not confuse or defraud the Department);
    c. Ensure marketing materials are available and understandable for the client population being served;
    d. Avoid offering other insurance products as an inducement to participate;
    e. Comply with federal requirements for provision of information including accurate oral and written information sufficient for the client to make an informed decision about treatment options; and
    f. Avoid any direct or indirect door-to-door, telephonic or other "cold-call" marketing;
17. Comply with the Department's continuous Quality Assurance/Quality Improvement activities, provide MH/SA services meeting the Department's quality standards, and comply with all requests for reports and data to ensure that QA/QI performance measures are met (See Section 6-000);
18. Meet all requirements of the Americans with Disabilities Act (ADA) and provide appropriate accommodations for clients with special needs. Ensure providers are equipped in appropriate technologies, e.g., TTY/TDD, and are skilled in various languages and areas of cultural diversity/sensitivity, and/or the network is appropriately staffed to ensure an adequate selection for those clients who have special cultural, religious or other special requests;

19. Coordinate activities with the Department, other NHC contractors, and other providers for services, as appropriate, to meet the needs of the client, and ensure systems are in place to promote well managed patient care, including, but not limited to:
    a. Management and integration of MH/SA services through the MH/SA provider, coordination of care issues with other MH/SA providers outside the MH/SA plan and for services not included in the NHC Benefits Package;
    b. Required referral/prior authorization requirements for medically necessary services;
    c. Provision of or arrangement for emergency treatment services, 24 hours per day, seven days per week, including an education process to help assure clients know where and how to obtain medically necessary care in emergency situations;
    d. Provision of transportation for MH/SA services;
    e. Unrestricted access to protected services such as emergency room services, tribal clinics, etc., according to 471 NAC;
    f. Clearly identified expectations for the MH/SA providers, subcontractors and any other providers participating in the client's managed care and documentation of that care for quality assurance/quality improvement purposes;
    g. Retention of records and other documentation during the period of contracting, and for three years after the final payment is made and all pending matters are closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original three year period ends; and
    h. Adequate policy regarding the distribution of the client's medical records if a client changes from one provider to another;
20. Not refuse an enrollment or otherwise discriminate against a client solely on the basis of age, gender, race, physical or mental handicap, national origin, or type of illness or condition;
21. Require that all subcontractors meet the same requirements as are in effect for the MH/SA plan that are appropriate to the service or activity delegated under the subcontract;
22. Provide member services;
23. Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;
24. Comply with all applicable state and federal regulations, such as the prohibition against assisted suicide; inappropriate use of funds/profits, lack of mental health parity, and the noncompliance with the provisions of the Hyde Amendment;
25. Prohibit discrimination against MH/SA providers based upon licensing;
26. Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;

27. Allow clients with chronic or severe conditions or experience-sensitive conditions, e.g., HIV-AIDS, to go directly to a qualified provider within the MH/SA's network;
28. Ensure that providers inform clients about all treatment options, regardless of cost or whether such services are covered by the MH/SA plan, and that MH/SA providers are not prohibited or otherwise restricted from advising clients about their health status, medical care, or treatment regardless of benefit coverage if the MH/SA provider is acting within his/her scope of practice. This does not require the MH/SA plan to cover counseling or referral if it objects on moral or religious grounds and makes available information regarding policies to clients who are enrolled with the MH/SA plan, or who may enroll with the MH/SA plan, within ninety days of a policy change regarding such counseling or referral services;
29. Provide written notice to the client of any adverse action (i.e., denial or reduction) regarding the provision of services that complies with all federal and state requirements, as described in the NHC Marketing and Client Information Procedure Guide (See 482-000-24) Allow clients to challenge decisions to deny, limit or terminate coverage of services. Clients shall be allowed to file complaints, grievances and appeals (see 482 NAC 7-000). Coordinate any denial of benefits with the HHS Protection and Safety worker and others who are functioning in an advocacy position with the client;
30. Report all fraud and abuse information to the Department in a timely manner;
31. Comply with the provisions of MH/SA provider payment (see 482 NAC 5-002.05C);
32. Maintain a Client Assistance Program with the following features:
    a. Direct client access to CAP services via walk-in or a toll-free telephone number. Prior authorization by the client's MH/SA provider or the MH/SA plan is not required to access the CAP;
        (1) The client is entitled to five CAP sessions per calendar year. The purpose of the CAP is to provide general outpatient counseling services, e.g., brief education, training, or behavioral intervention.
        (2) In cases where appropriate treatment cannot be provided by the CAP provider, the client must be referred to more appropriate MH/SA through the Mental Health and Substance Abuse Service Evaluation and Review function. All services beyond the CAP must be prior authorized through the MH/SA plan;
    b. Authorization by the MH/SA plan for the CAP services and payment of CAP services utilizing a prior authorization number;
    c. A triage and referral function at the CAP access point. This function must be equipped to determine the appropriate level of CAP care and MH/SA provider for the client; and
    d. A monitoring and tracking function to determine client CAP utilization. Client utilization of CAP services must be reported to the Department within the time frames specified in the MH/SA plan contract for NHC.

33. Develop an Evaluation and Review Function for the purpose of establishing a diagnosis, formulating a treatment plan, determining the level, duration, and intensity of services to be delivered with responsibility for:
    a. Initial client assessment by appropriately licensed MH/SA providers;
    b. Determination of level of MH/SA services required;
    c. Referral to the appropriate level of care;
    d. Monitoring quality of care;
    e. Outcomes measurements;
    f. Information transfer and feedback to primary caregivers; and
    g. Facilitate and coordinate admission to the appropriate level of care;
34. Provide a non-Medicaid-coverable services through a non-Medicaid enrolled MH/SA provider if the client's needs deem such a provision of service necessary;
35. Authorize services that require referral/prior authorization;
36. Maintain a record for each client;
37. Make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the plan or an answering service) or an answering machine that will immediately page an on-call treatment professional so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-off ice hours;
38. Provide utilization management as specified in its contract;
39. Meet performance goals specified in its contract;
40. Provide data and reports as specified in its contract;
41. Provide interpreter services for clients as specified in its contract; and
42. Provide training of providers on the NHC policy, processes, levels of treatment and application of medical necessity; and
43. Comply with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

5-002.05B Third Party Liability (TPL) Requirements: The MH/SA plan shall utilize a cost avoidance methodology whenever there is a verified third party resource (TPR). The following parameters apply:

1. The MH/SA plan, its subcontractors or providers, shall actively pursue, collect, and retain any monies from third party payers for the usual and customary charges on covered services to clients except when the amount of reimbursement the plan can reasonably expect to receive is less than the estimated cost of recovery; and
2. The MH/SA plan, its subcontractors or providers, may, at their sole discretion, compromise a claim against a third party payer, or may elect not to pursue the claim if they determine it is not cost effective to do so. The Department shall provide whatever assistance or assignments, as are necessary, to aid in the MH/SA plan’s collection efforts. Any recoveries by the MH/SA plan shall not affect continued payment of capitation for that client as long as the client remains enrolled in the NHC.

The Department has assigned to the MH/SA plan, or its subcontractors or providers, all rights to recover payments from third parties as provided by state law, in its contract with the MH/SA plan. TPL refers to any individual, entity, or program that is, or may be, liable to pay all or part of the cost of any medical services furnished to a client. Under federal law, the Department is required to identify legally liable third parties and treat the verified third party as a resource of the client. The MH/SA plan, its subcontractors or its providers shall not pursue collection from the client but directly from the liable third party payers, except as allowed in 468 NAC, 469 NAC, and 477 and 480 NAC.

TPL includes, but is not limited to:

1. Health insurance (private or group, including ERISA);
2. Casualty insurance;
3 Medicare;
4. Workers' Compensation;
5. Other federal program unless excluded by statute, such as Indian Health Service programs and Migrant Health programs; and
6. Any other party legally obligated to pay medical expenses.

The MH/SA plan agrees to:

1. Take responsibility for pursuing TPR for clients in the above categories;
2. Make reasonable attempts to identify TPR within its existing resources, but the primary responsibility for identifying TPR and communicating that information to the plan is with the Department or its designee. The Department shall retain the responsibility for collecting the medical support from absent parents;
3. Provide available information to, and cooperate with, the Department in its effort to collect those resources;
4. To track its TPL recoveries for its enrolled clients and to report these recoveries to the Department using the guidelines listed below. The Department shall supply the MH/SA plan with available TPL information for enrolled clients on the monthly enrollment report;
5. Maintain records of all third party recoveries and report this recovery activity to the Department on a monthly basis in a form and manner agreeable to both parties. The MH/SA plan's recovery activity report shall detail any recovery activity taken by the MH/SA plan against any of the TPR. Activity shall include, but is not limited to:
    a. Filing a lien,
    b. Submitting a bill,
    c. Receiving payment,
    d. Working with a client's legal representative, and/or
    e. Receiving a denial from a TPR;

6. On claims paid by the MH/SA plan, submit claims to health insurers within sixty days following notification of an available TPR;
7. In a liability situation, file a lien if lawfully permitted, within thirty days following notification of the available liability resource; and
8. Notify the Department of clients who refuse to assist the MH/SA plan and the Department in enforcing TPR recovery.

(See 482-000-25, TPR Procedure Guide.)

5-002.05C Provider Payments: The following provisions apply:

5-002.05C1 Timeliness of Provider Payments: The MH/SA plan shall provide payment to a provider of services on a timely basis, consistent with Medicaid claims payments procedures and the minimum standards provided below, unless the health care provider and organization agree to a capitated payment schedule or other arrangement.

The MH/SA plan shall provide an information system that includes the capability to electronically accept claims for adjudication and make payments. Such electronic system shall have the ability to transmit data to a central data repository which complies with the requirements for confidentiality of information under the Medicare program.

The MH/SA plan shall comply with the following minimum timeframes for the submission and processing of clean claims. Timeframes are calculated from the day the clean claim is received by the plan until the date of the postmark that either returns the claim to the provider or until posted on a electronic system.

All "clean" claims were to be adjudicated (i.e., paid, denied, or have the deductible applied to them) within 30 days from the date of receipt.

5-002.05C2 Prompt Investigation and Settlement of Claims: The MH/SA plan shall comply with the requirements related to claim forms as set forth in 471 NAC. This shall include the use of Form HCFA-1500, Health Insurance Claims Form for providers of outpatient services and Form UB-92 for hospitals providing inpatient or outpatient services. Any claim forms or submission methodology developed by the MH/SA plan for use by the providers shall be approved by the Department and must be in a format as to assure the submission of authorization and claims data.

5-002.05C3 Definitions: For purposes of 482 NAC 5-002.05C, the following words shall have the following meanings, unless the context clearly indicates otherwise:

"Claims" means a request for payment for service rendered or supplies provided by the provider to a client.

"Clean Claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstances requiring special treatment that otherwise prevents timely payment being made on the claim.

"Returned Claim or Contested Claim" means a claim that has not been adjudicated because it has a material defect or impropriety.

5-002.05C4 System Requirement: The MH/SA plan shall establish and maintain an editable system for recording all claims, clearly indicating the date on which a claim is received and the date(s) any action(s) on the claim occur, which shall also include an identified of the office handling the claim on behalf of the MH/SA plan.

5-002.05C5 Payment Standard: The MH/SA plan shall pay clean claims promptly as provided above after the date the plan receives written or electronic notice of the claim. If, for whatever reason, the claim is submitted electronically and in written form, the date of the earlier submission of the claim will be the date of notice from which the MH/SA plan shall calculate the maximum thirty day period.

5-002.05C6 Notice of Contested Claim: The MH/SA plan shall provide written or electronic notice to the provider of a determination by the plan that the claim is a contested claim with the returned claim. The written or electronic notice shall comply with the provisions in 482 NAC 5-002.05C.

5-002.05C7 Notice Requirement for Partially Contested Claim: If the MH/SA plan determines that part of a claim is a contested claim and returns the claim, the MH/SA plan shall provide written or electronic notice of that determination to the person submitting the claim and shall proceed to pay the portion of the claim determined by the plan to be a clean claim promptly, but no later than thirty calendar days following the date that the plan receives the written or electronic notice of claim.

5-002.05C8 Prohibited Action: In no instance shall the plan contest or return a claim or a portion of a claim because the claim fails to provide certain information if the information determined to be lacking has no factual impact upon the MH/SA plan's ability to adjudicate the claim.

5-002.05C9 Notice of Insufficient Information: If the MH/SA plan determines that a claim provides insufficient information for the MH/SA plan to deny the claim, the plan shall provide written or electronic notice of this determination to the person submitting the claim or member, if different from the person submitting the claim, promptly but in no instance later than thirty calendar days following the date that the plan receives written or electronic notice of the claim, including the following information:

1. All of the reasons for the denial of the claim;
2. The date the service was rendered, the type of service rendered, the name of the provider who rendered the service and the name of the person to whom the service was rendered; and
3. The address of the office responsible for handling the claim, and means by which the office may be contacted without toll charges exceeding the charges that otherwise apply for the provider or member to place a call in his/her areas code.

5-002.05C10 Effective Notices and Payments: Written notice of a claim shall be effective upon the date that the claim is received at the address provided by the MH/SA plan to the providers for receipt of claims of the type submitted. However, if the provider and the MH/SA plan agree to administer claims by electronic transmission, the plan shall have constructive notice of the claim as of the date the claim is posted to the electronic transfer system.

Payment from the MH/SA plan shall be effective as of the date that:

1. A draft or other valid instrument equivalent to payment is placed in the United States mail in a properly address, postage-paid envelope;
2. The date the MH/SA plan posts the item to an electronic transfer system; or
3. The date of delivery of the draft or other valid instrument equivalent to payment if 1 or 2 do not otherwise apply.

Payment and notices distributed by a MH/SA plan's subcontractor shall be effective when made in compliance with this section, as appropriate.

Notices from the MH/SA plan shall be effective as of the date that the notice is:

1. Placed in the United States mail in a properly addressed, postage paid envelope;
2. Posted to an electronic system; or
3. Delivered if 1 or 2 do not otherwise apply.

5-002.05C11 Contents of a Notice of a Contested Claim: The MH/SA plan shall specify in its notice of a returned claim at least the following information:

1. The name, address, telephone number and facsimile number of the office handling the claim or other designated claims representative knowledgeable about the claim with which the person submitted the claim, or provider should communicate to resolve problems with the claim;
2. The date of the service, the type of service, the provider of the service, and the name of the person to whom the service was rendered to the extent that this information is known to the MH/SA plan;
3. The specific information needed by the MH/SA plan to make a determination that the claim is a clean claim; and
4. The date the claim was received.

In addition, the MH/SA plan shall include in a notice regarding a claim that the plan has determined in part a contested claim, a statement specifying those portions of the claim that are considered to be clean claim, and the amounts payable with respect to the clean claim portion.

Requests for information made by the MH/SA plan on a contested claim shall be reasonable and relevant to the determination of whether the claim is a clean claim or claim that shall be denied.

The MH/SA plan and the Department shall agree upon a form for the information necessary to satisfy the requirements of 482 NAC 5-002.05C.

5-002.05C12 Use of Intermediaries: A MH/SA plan's use of subcontractors to perform one or more of the plan's claims handling functions shall not in any way mitigate a plan's responsibility to comply with all of the terms of 482 NAC.

5-003 MH/SA Package General Provisions: All services provided under the NHC must meet the requirements of 471 NAC unless specifically waived by the Department. The provider and MH/SA plan shall apply the same guidelines for determining coverage of services for the NHC client as the Department applies for other Medicaid clients. Actual provision of a service included in the MH/SA Package must be based on whether the service could have been covered under the Nebraska Medical Assistance Program on a fee-for-service basis under Title 471 NAC.

Copayments are not required for Mental Health/Substance Abuse (MH/SA) services for clients enrolled in the NHC, except for services not included in the MH/SA Package.

All services in the MH/SA Package must be provided or approved by the MH/SA plan.

Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization or provision by the MH/SA plan.

All covered emergency services will be available 24 hours per day, seven days per week, and shall not be limited to plan-affiliated providers. The client may access these services from any Medicaid-enrolled MH/SA provider s/he chooses, and is not limited to MH/SA providers within the MH/SA plan's network. The client may access these services without a referral, even if the MH/SA plan contracts with Medicaid to provide these services.

The Department requires the MH/SA plan to reimburse MH/SA providers, network and out-of-network, for appropriate medical screening performed during an emergency room visit. The payment of claims to out-of-network providers are subject to the requirements in 482 NAC 5-004.05C. Only non-Medicaid-coverable services may be provided by a non-Medicaid-enrolled provider.

Electronic referral/authorization shall be provided in accordance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

5-004 Services in the MH/SA Package: Services included in the MH/SA Package:

1. Outpatient services, including -
   a. Evaluations and assessments by physicians and licensed psychologist;
   b. Pre-treatment assessment;
   c. Individual psychotherapy;
   d. Individual substance abuse counseling (for clients age 20 and younger only);
   e. Group psychotherapy;
   f. Group substance abuse counseling (for clients age 20 and younger only);
   g. Family psychotherapy services;
   h. Family substance abuse counseling (for clients age 20 and younger only);
   i. Family assessment;
   j. Conferences with family or other responsible persons advising them on how to assist the client (for clients age 20 and younger only);
   k. Mileage for home-based family therapy or counseling services (for clients age 20 and younger only);
   l. MH/SA Community Treatment Aide (for clients age 20 and younger); and
   m. Intensive Outpatient Services;
2. Day treatment;

3. Treatment foster care (for clients age 20 and younger);
4. Treatment group home (for clients age 20 and younger);
5. Residential treatment center (for clients age 20 and younger);
6. Crisis intervention, which consists of -
    a. Observation room services;
    b. Residential acute (for clients age 20 and younger);
    c. Non-residential and treatment foster care (for clients age 20 and younger);
7. Acute Hospital Services;
8. Family Preservation;
9. Inpatient services;
10. Non-emergency transportation;
11. Coordinated MH/SA services (see 471 NAC 20-000 and 32-000 and 482 NAC 5-006);

Medicaid regulations governing coverage of these services are contained in 471 NAC. The services above represents covered services under the Nebraska Medical Assistance Program (NMAP) (see 471 NAC 20-000 and 32-000).

The MH/SA plan shall provide the above services in amount, duration and scope defined by the Department in 471 NAC. The MH/SA plan shall provide care and services when medically necessary to ensure the client receives necessary services. The MH/SA plan shall also ensure that the services provided to the client are as accessible (in terms of timeliness, amount, duration and scope) as those services provided to the non-enrolled Medicaid client.

In the interest of providing comprehensive services to the client, the MH/SA plan shall provide medically necessary services to the client that are in addition to those covered under the Nebraska Medical Assistance Program. If additional services are provided, the total payment to the MH/SA plan shall not be adjusted but shall remain within the rates agreed upon in any resulting contract.

5-005 Services for Emergency Medical Conditions: Prior-approval by the client's MH/SA provider and plan is not required for receipt of emergency services. The EBS shall inform NHC clients that the MH/SA provider and plan approval of emergency services is not required and shall educate clients regarding the definition of an "emergency medical condition," how to appropriately access emergency services, and encourage the client to contact the MH/SA provider and plan before accessing emergency services

5-005.01 Emergency Services Provided to NHC Clients: The MH/SA plan has no obligation to pay for emergency services unless the provider of the emergency services submits a bill within ninety calendar days of the date services were provided.

If the MH/SA plan has reasonable basis to believe any covered services are claimed to be emergency services were not in fact emergency services, payment may be denied for the services; provided that within ninety calendar days of receipt of a claim for payment:

1. The MH/SA provider of the services is notified of the decision to deny payment, the basis for that decision, and the provider's right to appeal that decision by requesting a hearing (see 482 NAC 7-002.01); and
2. The client is notified of the decision to deny payment, the basis for that decision, and the client's right to appeal (see 482 NAC 7-002).

The MH/SA plan shall provide a triage or medical screening fee to determine if a medical emergency exists.

The MH/SA plan shall comply with and implement any Departmental hearing decision, subject to any further rights to appeal.

An emergency medical condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, b) serious impairment to such person's bodily functions, c) serious impairment of any bodily organ or part of such person.

5-006 Medical/Surgical Coordination Issues: The following rules apply when coordination of services is required between the medical/surgical plan responsible for the Basic Benefits Package and the MH/SA plan responsible for the MH/SA services, as addressed by the Department in regulations governing both components of the NHC. In situations where the client isn't participating in both components of the NHC, the associated service is coordinated with the Nebraska Medicaid Assistance Program on a fee-for-service basis.

5-006.01 Emergency Room Services for MH/SA Services: Emergency room services provided to a client who is participating in the MH/SA component of the NHC is the responsibility of the client's medical/surgical plan regardless of the client's final or principle diagnosis.

At the time a MH/SA provider initiates an evaluation and/or treatment for the client, the medical/surgical plan is no longer responsible for MH/SA related service. Authorization for MH/SA services from that point forward must be obtained from the MH/SA plan.

5-006.02 Admissions for 24-Hour Observation: When a client who is participating in the MH/SA component of the NHC is admitted to an acute care (i.e., medical/surgical) facility as an outpatient for 24-hour observation (for purposes of a MH/SA diagnosis), the MH/SA plan is responsible for payment of the observation stay. Authorization for the admission must be obtained from the MH/SA plan.

The MH/SA plan is no longer responsible for the service at the time that a psychiatrist initiates an evaluation and/or treatment of the client and determines that the client does not have a MH/SA diagnosis. Authorization for medical/surgical services from that point forward must be obtained from the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC.

5-006.03 Chemical Detoxification Services and Substance Abuse Treatment: Chemical detoxification is a covered service for clients of any age. Authorization for hospital admissions must be obtained from the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

Substance abuse treatment services are covered for Medicaid-eligible clients age 20 and the younger only. Allowable substance abuse services for a client must be authorized by the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

5-006.04 History and Physical (H&P) Exams for Inpatient Admissions for MH/SA Services: The H&P completed for an inpatient admission for MH/SA services is the responsibility of the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC. The physician completing the H&P must obtain authorization from the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

Inpatient MH/SA services provided to clients participating in the MH/SA component of the NHC in a freestanding or hospital-based residential treatment center (RTC), treatment group home are the responsibility of the MH/SA plan. H&Ps provided to NHC clients for these allowable services are responsibility of the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC.

5-006.05 Ambulance Services for NHC Clients Receiving MH/SA Treatment Services: Emergency medical transportation, regardless of diagnosis or condition is the responsibility of the medical/surgical plan, if the client is participating in the medical/surgical component of the NHC.

All other medically necessary ambulance services are the responsibility of the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

Non-ambulance and non-emergency medical transportation for MH/SA services is the responsibility of the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

5-006.06 Injections Associated with MH/SA Services: Injections of psychotropic drugs, such as Haldol and Prolixin, in an outpatient setting, are the responsibility of the client's MH/SA plan, if the client is participating in the MH/SA component of the NHC.

5-006.07 Lab, X-Ray and Anesthesiology Associated with MH/SA Services: Services associated with the treatment of MH/SA services and authorized by a MH/SA provider participating in the MH/SA plan's network, such as lab fees, x-ray charges and the administration of anesthesiology, is the responsibility of the MH/SA plan, if the client is participating in the MH/SA component of the NHC.

5-007 Federally Qualified Health Centers (FQHC): If MH/SA services are provided by the FQHC, the MH/SA plan shall contract with the FQHC or otherwise arrange for the provision of FQHC services. If an FQHC is reimbursed by the MH/SA plan on a fee-for-service basis, it cannot pay less for those services than it pays other providers. FQHC's electing to be reimbursed on a negotiated risk basis are not entitled to reasonable cost reimbursement. If the FQHC requests reasonable cost reimbursement, the MH/SA plan must reimburse the FQHC at the same rate it reimburses its other subcontractors. A medical/surgical plan that contracts with a FQHC shall report to the Department the total amount paid to each FQHC as specified in the contract. FQHC payments include direct payments to a medical provider who is employed by the FQHC.

The same reasonable efforts that are applied to the FQHC, apply to the Rural Health Clinics and Tribal Clinics.

5-008 Payment for Services: Payment of services provided to the MH/SA plan shall be a capitated payment. The Department pays a monthly capitation fee to the MH/SA plan for each enrolled client for each month of NHC coverage. The monthly capitation fee includes payment for all services in the MH/SA Package.

Payment to the MH/SA plan is payment in full for all services included in the MH/SA Package. No additional payment may be requested of the Department or the client.

5-008.02 Payment to the MH/SA Provider: The MH/SA plan shall provide payment to providers for services rendered on a timely basis, consistent with Medicaid claims payment procedures, unless the health care provider and organization agree to an alternative payment schedule. See Section 1-011.48.

5-008.03 Recoupments/Reconciliation: The Department shall not normally recoup payments from the plan. However, in situations where payments are made incorrectly, the Department shall work with the MH/SA plan to identify the discrepancy and shall recoup/reconcile such payments.

5-008.04 Enrollment Report: On or before the first day of the enrollment, the Department shall provide to the MH/SA plan a monthly enrollment report that lists all enrolled and disenrolled clients for the enrollment month. This report will be used as the basis for the monthly payments to the MH/SA plan. The MH/SA plan is responsible for payment of all services in the MH/SA Package provided to clients listed on the enrollment report generated for the month of coverage. Any discrepancies between the client's NHC Identification (ID) Document or any identification issued by the MH/SA plan and the enrollment report must be reported to the Department for resolution. The MH/SA plan shall continue to provide and authorize services for the client until the discrepancy is resolved. If an eligible client is not listed on the enrollment report, the Department will be responsible for all services on a fee-for-service basis.

5-008.04A Coverage for Pregnant Women/Newborns: Coverage for a pregnant woman and/or the unborn/newborn is provided within the following parameters:

1. Pregnant Woman and Unborn/Newborn are Medicaid Eligible: Coverage is provided for the pregnant woman from the month of enrollment until disenrollment occurs; and for the unborn/newborn from the month of expected birth until disenrollment occurs. Payment to the MH/SA plan is made for the month(s) of enrollment for the pregnant woman and the unborn/newborn until disenrollment occurs.
2. Only the Unborn/Newborn is Medicaid Eligible: Coverage is provided for the pregnant woman through the eligibility/enrollment of the unborn/newborn from the month of enrollment until disenrollment occurs. Coverage for the mother and newborn is provided for the month of expected birth through the month in which the 60th day following the month of expected birth occurs. Coverage for only the newborn continues past the 60-day postpartum period as long as the newborn remains eligible and enrolled. Payment to the MH/SA plan is made for the month(s) of enrollment and/or coverage for the pregnant woman and the unborn/newborn until disenrollment occurs. (See 482-000-14.)

5-009 Payment for NHC Services - MH/SA Plan: The Department pays a monthly capitation fee to the MH/SA plan for each enrolled client for each month of NHC coverage. The monthly capitation fee includes payment for all services in the MH/SA Package.

The MH/SA plan shall provide payment to providers for services rendered on a timely basis, consistent with Medicaid claims payment procedures, unless the health care provider and organization agree to an alternative payment schedule.

Payment to the MH/SA plan is payment in full for all services included in the MH/SA Package. No additional payment may be requested of the Department or the client.

These rates are actuarially determined and are based on geographic location, eligibility category, gender, age and type of services. The Department shall adjust rates, and complete all necessary contract amendments, when it is determined appropriate, based on any changes in the Upper Payment Limit, Medicaid fee-for-service (FFS) rates, or in instances where the an error or omission in the calculation of the rates has been identified.

5-010 Billing the Client: The MH/SA plan may not bill a client for a Medicaid coverable service, regardless of the circumstances.

A provider of service may only bill the client pursuant to 471 NAC.

The MH/SA plan may or may not be responsible for an out-of-network service if the service is a Medicaid-coverable service. Whether the MH/SA plan is responsible to pay the provider is determined by the agreement the MH/SA plan has with that provider. In some cases, the provider may not get paid.

Note: The MH/SA plan is not required to pay a non-Medicaid enrolled provider for a Medicaid-covered service.